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MEDICAL CIVIL RIGHTS: THE EXCLUSION OF PHYSICIANS OF COLOR FROM MANAGED CARE: BUSINESS OR BIAS?

RENE BOWSER*

Introduction

The United States is rapidly becoming more diverse, as demonstrated by the fact that nonwhite racial and ethnic minorities will likely constitute a majority of Americans later in this century.[1] The representation of African Americans, Latino/as, Asian Americans, and Native Americans in medicine, however, has grown only modestly over the past 25 years, producing a trend in which the proportion of minorities in the population outstrips their representation among physicians by several fold.[2] Latino/as, for example, comprise 14.4 percent of the U.S. population,[3] but only 3.2 percent of physicians.[4] Similarly, African Americans comprise almost 13 percent of the population,[5] but only about 2.5 percent of physicians.[6]

Managed care organizations (MCOs)[7] are signing up growing

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1. *See* IN THE NATION'S COMPELLING INTEREST: ENSURING DIVERSITY IN THE HEALTH-CARE WORKFORCE 23 (Brian D. Smedley, Adrienne S. Butler & Lonnie R. Bristow eds., 2003).

2. *Id.*

3. Population of the United States by Race and Hispanic/Latino Origin, Census 2000 and July 1, 2005, *available at* http://www.infoplease.com/ipa/A0762156.html (last visited Nov. 20, 2006) [hereinafter Population]

4. AMERICAN MEDICAL ASSOCIATION, PHYSICIAN CHARACTERISTICS AND DISTRIBUTION IN THE UNITED STATES 41 (2005) (showing Hispanics make up only 28,415 of the 871,535 U.S. physicians).

5. *See* Population, *supra* note 3.

6. *See* AMERICAN MEDICAL ASSOCIATION, *supra* note 4, at 41 (showing only 20,854 U.S. physicians are African American).

7. Managed care organizations provide health care finance and delivery through a

numbers of minority patients, but few minority physicians appear on the provider lists. Demographics are a major factor, of course, and much legal and policy analysis has focused on ways of increasing the pool of minority physicians. Another concern is that MCOs' contracting decisions may be discriminatory based on the characteristics of minority physicians or their patients. This article focuses on non-supply related institutional norms and practices that present significant barriers to entry for minority physicians.

Many physicians of color believe that MCOs disproportionately reject their membership applications, terminate their contracts at a much higher rate compared to white physicians, and unjustly "tax" those patients of color wanting to receive medical care from a physician of their own racial or ethnic background.[8] In a 2003 Gallup survey of African-American physicians, almost 50 percent indicated dissatisfaction with the treatment of African-American physicians by managed care health plans.[9] In another survey of African-American doctors, 92 percent felt that MCOs terminate their contracts more often than white physicians.[10]

Managed care's selection and de-selection criteria appear objective and race-neutral. However, while not purposely designed to exclude, many of these criteria have had a significant adverse impact on both minority physicians and the patients they serve. For instance, practice in a large medical group is practically a prerequisite to enter a managed care provider network. Yet, nearly 75 percent of African-American physicians are in solo practice.[11]

In the end, the direct impact of exclusionary practices is felt by patients of color. Patient choice in selecting physicians of like background is severely restricted, ultimately compromising quality health care. Studies show that minority patients use more services, are more satisfied with health care and, in some instances, have better outcomes when they receive care from physicians of their

confusing array of organizational structures, including health maintenance organizations (HMOs), preferred provider organizations (PPOs), and integrated delivery systems. Rather than focus on the taxonomy, Hacker and Marmor stress the three essential features of MCOs—risk sharing between provider and insurer, administrative oversight of clinical decisions, and the use of physician provider networks. *See* Jacob S. Hacker and Theodore R. Marmor, *How Not to Think About "Managed Care,"* 32 U. MICH. J. L. REFORM 661 (1999).

8. *See infra* Part I.

9. *See* L. Natalie Carroll and Sharon Allison-Ottey, *The Joy is Gone – Results of the NMA/Gallup Survey of African-American Physicians*, 96 J. NAT'L MED. ASS'N 419, 427 (2004).

10. *See* Risa Lavizzo-Mourey et al., *The Perceptions of African-American Physicians Concerning Their Treatment by Managed Care Organizations*, 88 J. NAT'L. MED ASS'N. 210, 211-12 (1996).

11. *See infra* Part II.B.

own racial or ethnic background.[12] In 2001, Dr. Rodney G. Hood described the situation this way:

> Thirty years ago, African-American physicians treated more than 90 percent of African Americans. Today, white physicians treat two thirds of the African-American population. Some of that is by choice, but a lot of it has to do with the African-American population being disenfranchised from African-American physicians. I've been in practice for over 20 years, and I can't tell you the number of patients who wanted to choose me but couldn't because I wasn't part of the health plan that covered them. They tell me they have to go elsewhere, usually to a larger group that may or may not have a physician that looks like them.[13]

This article analyzes whether managed care is biased against minority physicians in five sections. Part I looks at the allegations of bias made by physicians of color and examines the statistical evidence supporting the claims. Part II analyzes some of the norms and practices of MCOs and suggests that many of these unwittingly devalue the efficiency of minority physicians and the quality of care they provide, which leads to inequitable actions and decisions. Moreover, this part shows how exclusion from provider networks potentially widens the racial health gap. Part III focuses on the history of exclusion within the medical profession. This history is important because it helped shape the organizational structure of minority physician practices, dictated the types of patients they served, influenced the location of their practices, and illustrates how white physician self-interest continuously defeated the equity demands of both minority patients and physicians.

The concluding two parts discuss remedies and legislative reforms. Part IV focuses on remedies at the federal level and analyzes the adequacy of existing civil rights laws and finds that they are not well suited to redress discrimination in the medical market. As an alternative to civil rights enforcement under existing law, this article suggests that the problem of exclusion is better addressed by revising health care quality mandates contained within the Social Security Act to require the collection and analysis of provider race and ethnicity data. Finally, Part V examines the state and local remedies and legislative reforms, and suggests that well-crafted provider panel diversity ordinances and physician due

12. *See infra* Part II.D.

13. *Fighting Invisible Barriers To Equitable Health Care: A Conversation With Rodney G. Hood, M.D.*, MANAGED CARE, February 2001, *available at* http://www.managedcaremag.com/archives/0102/0102.qna_hood.html.

process statutes provide the most realistic avenues for relief.

I. Allegations of Discrimination in Provider Networks

Physicians of all races and ethnicities have long had a litany of complaints against MCOs. Providers have complained about interferences with medical decision-making, financial incentives to render less care, and the burdensome administrative costs of complying with plans' care management policies.[14] Much less publicized and more frequently ignored is the very serious complaint of some African-America, Latino/a and Asian-American physicians - MCOs effectively discriminate against them.

A. Allegations of Discrimination

In January 2000, the National Medical Association (NMA), the nation's largest group of African-American physicians, alleged that managed care health plans were excluding a disproportionate number of minority physicians from physician provider networks nationwide.[15] Not only were health plans not accepting African-American and Latino/a doctors, the health plans were also terminating the contracts of some members.[16] According to the NMA, in geographic areas in which managed care health plans are the dominant form of health care delivery, some physicians of color have ceased to be able to practice medicine, others have been forced to relocate, and still others have been discouraged from establishing practices.[17]

Physicians of color in Atlanta, Baltimore, Kansas City, Cincinnati, Washington, D.C., and other cities have alleged that they

14. *See, e.g.*, John Jacobi, *After Managed Care: Gray Boxes, Tiers and Consumerism*, 47 ST. LOUIS U. L.J. 397 (2003).

15. *See NewsHour: Race in Health Care* (PBS television broadcast Jan. 25, 2000) [hereinafter "*Race In Health Care*"], *available at* http://www.pbs.org/newshour/bb/health/jan-june00/race_1-25.html; *see also* Walter W. Shervington, *Discrimination Among Major Health Plans Plague Nation's Minority Physicians and Patients*, 92 J. NAT.'L MED. ASS'N 103, 103 (2000).

16. *See NewsHour, supra* note 15; Shervington, *supra* note 15, at 104. The NMA president Dr. Walter Shervington described the situation: "There are still too many black and Latino doctors being kicked out of plans for no reason and too many black and Latino physicians enrolled as patients in plans that do not allow access to physicians of the same race." *Id.*

17. *See NewsHour, supra* note 15.

had been locked out of provider networks.[18] Most recently, black physicians practicing in Las Vegas held a May 18, 2005, press conference to protest discriminatory managed care practices.[19] The exclusion of blacks from MCO contracts was motivated by greed and the desire to decrease the number of doctors competing for patients, they stated.[20] Because negotiation has not worked, the group plans to file a class action lawsuit alleging race discrimination.[21] Ten years earlier, black physicians had expressed similar concerns before the Nevada State Legislature.[22] Speaking for the group, Dr. James Tate testified that there was a definite lack of acceptance of African-American physicians: "MCOs might accept one or two family practitioners, but when it comes to specialists, the usual answer would be that the MCOs had all the doctors they needed."[23]

America's Health Insurance Plans, a trade group representing the managed care industry, denies that health plans consider race in making physician selection and termination decisions.[24] Health plans are actively recruiting physicians of color, according to the group, and demographics are the major obstacle to provider diversity. Furthermore, the association states that its members share a commitment to delivering culturally competent care.[25]

A recent federal lawsuit illustrates the concerns. In 2000, eight primary care physicians sued Humana and its local affiliate alleging that Humana had unlawfully terminated them from a provider network because of their race and ethnicity.[26] In their complaint, the plaintiffs alleged that during the time in which Humana terminated their contracts, all seventeen white physicians on the Humana panel

18. *See, e.g.*, Gina Shaw, *Are Managed Care Companies Squeezing Out Black Physicians?*, American Association of Medical Colleges Reporter, Apr. 2000, *available at* http://www.aamc.org/newsroom/reporter/april2000/squeeze.htm; Cindy Starr, *The Disappearing Black Doctor*, The Cincinnati Post, May 8, 1998, *available at* http://cincypost.com/news/1998/docs060698.html.

19. Nevada Public Radio, DISCRIMINATION (KNBR audio broadcast May 18, 2005), *available at* http:/www.knpr.org/archive/detailNEW.cfm?FeatureID=2341.

20. *Id. See also* Cathy Scott, *Black Physicians Accuse UMC of Racial Discrimination*, May 12, 2005, *available at* http://www.lasvegascitylife.com/articles/2005/05/12/local_news/news02.txt.

21. *See* Nevada Public Radio, *supra* note 19.

22. Nevada Senate Committee on Commerce and Labor, Sixty-eighth Session, Jan. 25, 1995, *available at* http://www.leg.state.nv.us/68th/minutes/SCL125.txt.

23. *Id.*

24. *See* Shaw, *supra* note 18.

25. *See, e.g.*, Stephanie L. Taylor et al., *The Role of Cultural Competency in Reducing Ethnic and Racial Healthcare Disparities*, 10 AM. J. MANAGED CARE 4 (2004).

26. *See* Thiruchelvam v. Humana Health Insurance Plan, No. FL-M 6:00-cv-01542 (M.D. Fla. filed Nov. 16, 2000).

remained with the MCO.[27] The plaintiffs also alleged that after terminating them, Humana rerouted their patients to the seventeen white primary care physicians.[28]

Humana answered that race and ethnicity had nothing to do with the decision not to renew the contracts, and that the terminations were for business reasons.[29] A Humana spokeswoman, Pam Gadinsky, stated that the health plan wanted to trim back the provider network.[30] She further indicated that each of the eight physicians had "high deficits" and were unable to manage in an HMO environment.[31] According to Gadinsky: "There are some doctors who are successful working in the managed care setting, and some who are not."[32] In February 2003, Humana and the plaintiffs settled the lawsuit for $3,200,000.[33] As a result, the district court did not reach the central issue of whether the termination decisions were motivated by race or legitimate business reasons. In the only other known case, Kansas City black doctors settled with a local insurance company, acting as an MCO, after alleging racially exclusionary practices.[34]

Some physicians of color have admitted that there is no hard data confirming the allegations of discrimination. In this respect, they have compared the problem to the same difficulty black and Latino drivers initially faced in providing evidence to support allegations of racial profiling.[35] In 2001, the NMA asked the American Medical Association (AMA) for its support for a focused review of current managed care contracts between health plans and minority physicians. The AMA has yet to act, a fact that is quite understandable, given the history of contention between the two groups, and their longstanding and persistent differences in ideology and perception.[36]

Recent passage of the Medicare Prescription Drug, Improvement and Moderation Act of 2003[37] (MMA) raises the stakes considerably. The legislation offers expansive financial and structural incentives to attract and retain HMOs and PPOs operating in the Medicare program. Since 1998, MCOs have dropped out of

27. Complaint ¶ 21, Thiruchelvam, No. FL-M 6:00-cv-01542.
28. *Id.* ¶ 22.
29. Answer ¶¶ 9-11, Thiruchelvam, No. FL-M 6:00-cv-01542.
30. *See* Susan Lundine, *Minority Docs Dumped by Humana Allege Bias*, ORLANDO BUS. J., Jan. 12, 2001, at A3.
31. *Id.*
32. *Id.*
33. *Id.*
34. *See* Shaw, *supra* note 18.
35. *See NewsHour*, *supra* note 15.
36. *See infra*, Part III.C.
37. Medicare Prescription Drug and Modernization Act, 42 U.S.C.A § 1395 (2003).

the Medicare market at an alarming rate due to unprofitable operations.[38] The subsidies contained within the MNA seek to reverse that trend, giving preferential treatment to HMOs and PPOs through payment rates that will be 25 percent higher than those paid to traditional Medicare fee-for-service providers, and establishing "risk corridors" and a stabilization fund to limit exposure to market risk.[39] To ensure managed care plan participation in Medicare Advantage, the MNA has increased aggregate payments by $1.3 billion for 2004 and 2005.[40]

The planned expansion of profit-driven MCOs into Medicare has the potential to further increase the marginalization of physicians of color.[41] Traditional fee-for-service Medicare allows beneficiaries to choose from any physician who accepts Medicare payments. However, HMOs and PPOs, would restrict access to physicians by creating a limited network from which enrollees must select. These limitations could adversely affect physicians of color if they are not included in the network or are dropped from the

38. Michael Levin-Epstein, *Medicare+Choice Reform: Hope, But No Quick Action Expected,* Managed Care, Oct. 2001, *available at* http//:www.managedcaremag.com/archives/0110/0110.medicare_action.html (In 1997, Medicare managed care participation peaked at six million (one in seven beneficiaries)); Lori Achman & Marsha Gold, *Medicare+Choice 1999-2001: An Analysis of Managed Care Plan Withdrawals and Trends in Benefits and Premiums,* Commenwealth Fund, Publication No. 497, 2002, *available at* http:www.cmwf.org. (M+C withdrawals affected approximately 2.2 million Medicare beneficiaries between 1999 and 2002); Lori Achman & Marsha Gold, *Trends in Medicare+Choice Benefits and Premiums, 1999-2002* Commonwealth Fund, Publication No. 580, 2002, *available at* http://www.cmwf.org/programs/medfutur/achman_trendsM+C_580.pdf (noting that, in 2002, an estimated 536,000 M+C enrollees were affected); Timothy Lake & Randall Brown, *Medicare+Choice Withdrawals: Understanding Key Factors,* The Henry J. Kaiser Family Foundation, Publication No. 6046, 2002, available at http://www.kff.org/medicare (analyzing the decline in service areas covered by M+C contracts by percentage of existing M+C contracts and per M+C county); Colleen L. Barry & Janet Kline, *Medicare Managed Care: Medicare+Choice at Five Years,* The Commonwealth Fund, Publication No. 537, 2002, *available at* http:www.cmwf.org/programs/medfutur/barry_fiveyears_ib_537.pdf (noting that, since 1999, the number of beneficiaries with an HMO available in their area has decreased from 72 percent to 64 percent); Timothy D. McBride & Keith J. Mueller, *Inequitable Access: Medicare+Choice Program Fails to Serve Rural America,* 7 RURAL POLICY RES. INST. 1, 1-2 (2002).

39. *See* 42 U.S.C.A. § 1395w-132.

40. *See* Paulette Morgan & Hinda, Chaikind, Cong, Res. Services, *Medicare Advantage: What Does it Mean to Private Plans currently Serving Medicare Beneficiaries,* CRS Report RS21761, at 2-3 (Mar. 8, 2004).

41. *See* MAYA ROCKEYMOORE & LAURA HAWKINSON, CONGRESSIONAL BLACK CAUCUS FOUNDATION, INC., STRUCTURED INEFFICIENCY: THE IMPACT OF MEDICARE REFORM ON AFRICAN AMERICANS (2004), *available at* www.cbcfinc.org/pdf/Medicare_Reform.pdf (last visited Nov. 20, 2006).

Medicare health plan.[42]

B. Studies of Provider Exclusion

Despite the prevalence of managed care throughout the United States, little is known about its contracting patterns with providers. Only three studies have examined the issue of exclusion by race and ethnicity, and the results, while inconclusive, point to the existence of some differential treatment.

In the first study, done in 1998, the authors report that patient characteristics, not race or ethnicity, were the primary predictor of contract terminations.[43] Minority physicians did not experience a higher rate of denials or terminations than did white physicians.[44] Those doctors who care for a disproportionate number of uninsured and minority patients, however, were less likely to have managed care patients, an indication that these physicians may be excluded from full participation in the managed care setting.[45] Of the nonwhite physicians denied a contract, 20 percent believed it was due to racial discrimination, and 25 percent thought it was related to not being in the right social circles.[46] In the first national study, Mackenzie reported that while the results do not suggest rampant discrimination, there are troubling signs of differences in physicians' experiences based on race.[47] For instance, Asian-American physicians reported significantly more problems keeping contracts than white physicians. [48] Also, Latino/a physicians were

42. *Id.* at 11.

43. *See* Andrew B. Bindman et al., *Selection and Exclusion of Primary Care Physicians by Managed Care Organizations*, 279 JAMA 675 (1998). The researchers chose California for the study because of the high rate of managed care penetration across the state, and designed their questionnaire to focus on three main areas: the frequency with which physicians were denied or terminated from managed care contracts, the characteristics of the physicians and practices who had this experience, and the impact of the experience on the physicians' ultimate involvement with managed care. *Id.* at 676-77.

44. *Id.* at 678-79.

45. *Id.* at 679.

46. *Id.*

47. *See* Elizabeth R. Mackenzie et al., *Experiences of Ethnic Minority Primary Care Physicians With Managed Care: A National Survey*, 5 AM. J. MANAGED CARE 1251 (1999). The researchers identified four questions germane to the issue of ethnic minority presence in managed care: 1) experiences with managed care contract acquisition; 2) experiences with managed care contract termination; 3) patient attrition, and 4) perception of the ability to provide appropriate care. A total of 1032 physicians (67 percent white, 7 percent Latino/a, 8 percent black, 12 percent Asian, 0.4 percent Native American, 5 percent other) were randomly selected nationwide and asked detailed questions during a 25-minute telephone interview. *Id.* at 1252-54.

48. *Id.* at 1258-59.

substantially less likely to have managed care patients.[49] Race and ethnicity were not a significant predictor of difficulties in acquiring or maintaining contracts for other physicians.[50]

In 1999, the Maryland State Legislature appropriated funds and commissioned the Maryland Department of Health and Mental Hygiene to conduct a statewide study of Maryland physicians about their managed care experiences.[51] Released in September 2001, the Maryland Study on Physician Experience with Managed Care ("Maryland Study") suggests that the concerns of minority physicians may be warranted.

Generally, the Maryland Study found that the denial of applications to join a MCOs' provider network and termination of contracts by MCOs are not pervasive problems.[52] However, when these actions do occur, minority physicians are the group most affected. For instance, the Maryland Study found that, as a whole, minority physicians are more likely than white physicians to experience denials of membership requests to join a MCOs' provider network.[53] After adjustment for other variables such as practice type, specialty, board certification, and age, there remained a 15 percent difference between African Americans and whites in terms of denials, and a 4 percent difference between Asian Americans and whites.[54]

Likewise, the Maryland Study found that minority physicians are more likely to have contracts terminated than whites. The adjusted difference in contract terminations between African Americans and whites is 5 percent, and between whites and Asians, the adjusted difference is 12 percent.[55] Further, more African-American physicians perceived racial/ethnic discrimination as the primary reason for differences in contract denials and terminations than other groups, including Asian-American and Latino/a respondents.[56]

The conclusions of the provider exclusion studies must be viewed with caution. Generally, the studies suggest that minority physicians have been relatively successful in obtaining MCO

49. *Id.* at 1260.

50. *Id.* at 1258-59.

51. *See* MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE, THE MARYLAND STUDY ON PHYSICIAN EXPERIENCE WITH MANAGED CARE (2001), *available at* http://www.chpdm.org/publications/Physician%20Experience%20with%20Managed%20Care%20Report%20-%20September%202001.pdf.

52. *Id.* at 6.

53. *Id.* at 10.

54. *Id.*

55. *Id.* at 12.

56. *Id.* at 14.

provider contracts. Yet all MCO contracts are not the same; some are more lucrative than others. While physicians of color may be able to obtain contracts for lower paying Medicaid networks they may at the same time be denied access to employer-funded networks that MCOs establish to provide health care benefits to employees of large corporations and institutions.[57] Future research should compare the types of MCO contracts acquired by different racial/ethnic groups.

II. MCO Selection and De-selection Criteria: Implications for Minority Health

Managed care emerged the victor in the health finance reform battles of the early 1990s, and market-driven health care was widely viewed as the best alternative to the unbridled fee-for-service system.[58] Under a fee-for-service regime, doctors receive compensation for every office visit and for every procedure, which creates a substantial financial incentive for physicians to increase the provision of health services.[59] The market approach to health care finance and delivery committed complex problems of access, cost, quality, and equity to the business plans of commercial MCOs.[60] Market solutions, however, often comparatively disadvantage disfavored groups. On this point, Cass Sunstein asserts that, "study after study has shown that the market often devalues the products and enterprises of both blacks and women."[61] The market often devalues the preferences of minority consumers as well.[62]

This section of the article examines several ways in which profit-driven MCOs potentially mismeasure the efficiency and quality of minority physicians, and devalue the preferences of minority health care consumers. The starting point is an analysis of

57. *See* Jeremy Manier, *PUSH Charges Bias by Key HMO: United Healthcare Paying Less to South Side Doctors, Group Contends*, CHI. TRIB., Sept. 1, 1998, at N3.

58. *See, e.g.*, Karen Davis & Cathy Schoen, *Universal Coverage: Building on Medicare and Employer Financing*, 13 HEALTH AFF. 7 (1994); Mark V. Pauly, *Making a Case for Employer-Enforced Individual Mandates*, 13 HEALTH AFF. (1994); Paul Starr & Walter A. Zelman, *A Bridge to Compromise: Competition Under a Budget*, 12 HEALTH AFF. 7 (1993); Alain C. Enthoven & Richard Kronick, *Universal Health Insurance Through Incentives Reform*, 265 JAMA 2532 (1991); John Holahan et al., *An American Approach to Health System Reform*, 265 JAMA 2537 (1991).

59. *See* Alain C. Enthoven, *The History and Principles of Managed Competition*, 12 HEALTH AFF. 24, 25 (1993) (characterizing the traditional fee-for-service system as a guild).

60. *See* Jacobi, *supra* note 14, at 397.

61. CASS R. SUNSTEIN, WHY MARKETS DON'T STOP DISCRIMINATION 7 (1997).

62. *Id.*

race-neutral criteria that MCOs use to select and de-select physicians. This article suggests that these criteria are flawed and disproportionately subject minority physicians to inequitable decisions and actions. Next, this section turns to minority consumers and demonstrates that the exclusion of minority physicians from provider networks potentially widens health care disparities. Moreover, the exclusion of minority providers restricts the ability of minority consumers to satisfy their preference of having a physician of like racial and ethnic backgrounds, which leads to poorer patient satisfaction and outcomes.

A. Economic Profiling

Economic profiles are statistical pictures of physician costs and resource utilization expressed as rates and compared with other physicians and MCO guidelines.[63] MCOs often reward physicians with low economic profiles by placing them in more lucrative networks or increasing their compensation.[64] Physicians with high economic profiles are frequently denied admission to provider networks or terminated because MCOs consider these providers as costly and inefficient.[65] Though race neutral, the incidence of economic profiling falls primarily on minority providers and their patients. Minority physicians are more likely to serve minority populations.[66] Nearly 40 percent of all minority medical school graduates practice medicine in underserved areas, compared to 10 percent of their white colleagues.[67] Communities with high proportions of black and Latino/a residents are four times as likely as others to have a shortage of physicians, regardless of community income.[68] In these communities, black physicians provide 52 percent of the care for black patients, and Latino/a physicians provide 54 percent of the care for Latino patients.[69]

Physicians of color frequently have higher economic profiling

63. *See* John Blum, *The Evolution of Physician Credentialing into Managed Care Selective Contracting*, 22 AM. J.L. & MED. 173, 180 (1996); Jerome P. Kassirer, *The Use and Abuse of Practice Profiles*, 330 NEW ENG. J. MED. 634, 634 (1994) (describing the advent and manipulation of practice profiles).

64. *See* Linda Peeno, *The Second Coming of Managed Care*, 40 TRIAL 18, 26 (2004).

65. *See* NORBERT GOLDFIELD, PHYSICIAN PROFILING AND RISK ADJUSTMENT 8 (1999).

66. *See* Council Graduate Medical Education, *Twelfth Report: Minorities in Medicine*, May 1998, *available at* http:/www.cogme.gov/12.pdf.

67. *Id.*

68. *See* Miriam Komaromy et al., *The Role of Black and Hispanic Physicians in Providing Care for Underserved Populations*, 344 JAMA 1305 (1996).

69. *Id.* at 1309.

numbers because many of their patients need more services than the statistical norm.[70] Because of the lack of prior health care, racial and ethnic minorities and the underserved typically enter MCOs with a backlog of illnesses that have been inadequately treated or have gone untreated.[71] Because the illnesses are more severe, they require more intense treatment over a longer period, so that treatment falls outside of the normal course.[72] Even for illnesses developed after enrollment in an MCO, the course of the illness is likely to be longer and more severe.[73]

Logically, an adjustment should be made to economic profiling data to reflect differences in case-mix, given the objective of obtaining an accurate assessment of physician efficiency and cost-effectiveness.[74] Few MCOs, however, perform such an adjustment.[75] As one might expect, the current practice of not adjusting leads MCOs to overestimate physicians' variance from the statistical norm. For instance, Harvard researchers found that three-quarters of physicians identified as inefficient or high deficit providers fell within the statistically accepted range after adjustments were made to their economic profiles.[76] The NMA has urged MCOs not to go strictly by the numbers when selecting and de-selecting physicians, and has identified new software packages that risk-adjust the data.[77] The industry has not acted.

As a result, the current economic profiling practices understate the efficiency and cost-effectiveness of many minority physicians. Conversely, these practices may privilege many majority group

70. *See* Robert M. Mayberry et al., *Racial and Ethnic Differences in Access to Medical Care*, 57 MED. CARE RES. & REV. 108 (2000).

71. *See, e.g.*, David R. Williams and Chiquita Collins, *U.S. Socioeconomic and Racial Differences in Health: Patterns and Explanations*, 21 ANN. REV. SOC. 349, 367-68 (1995)

72. *See* Sidney D. Watson, *Health Care in the Inner City: Asking the Right Question*, 71 N.C. L. REV. 1647, 1647-54 (1993);

73. *Id.*

74. *See* Mark V. Pauly, *The Public Policy Implications of Using Outcome Statistics*, 58 BROOK. L. REV. 35, 37 (1992); DAVID W. EMMONS & GREGORY D. WOZNIAK, PHYSICIAN PROFILING IN SOCIOECONOMIC CHARACTERISTICS OF MEDICAL PRACTICE 9 (Martin L. Gonzalez ed., 1993).

75. *See* Huw Davies & Andrew Bindman, *Healthcare Report Cards: Implication for Vulnerable Patient Populations and the Organizations Providing them Care*, 27 J. HEALTH POL'Y & L. 379, 387 (2002) (finding that some MCOs adjust for patient age and sex only, while the vast majority ignore case mix adjustment altogether). Failing to adjust introduces into the MCO physician efficiency evaluation process the potential for bias based on race, ethnicity, and socioeconomic status. *Id.*

76. *See* S. Salem-Schatz et al., *The Case for Case-Mix Adjustment in Practice Profiling: When Good Apples Look Bad*, 272 JAMA 871 (1994). *See also* Timothy Hofer et al., *The Unreliability of Individual Physician 'Report Cards' for Assessing the Costs and Quality of Care of a Chronic Disease*, 281 JAMA 2098 (1999).

77. *See* Shaw, *supra* note 18.

physicians, especially those who serve healthier and more affluent patients. Further, they perversely penalize some minority patients by substantially limiting their ability to choose a provider of the same racial/ethnic background.

B. Medical Group Membership

MCOs prefer to contract with large medical groups because it lowers negotiating costs, and also because medical groups are more likely to engage in internal peer review.[78] Physicians of any race in solo practice have a harder time getting into managed care plans.[79] Minority physicians are disproportionately affected by the medical group membership requirement, however, because a higher percentage are solo practitioners. For instance, 75 percent of self-employed black physicians work in solo office-based practices.[80]

Even though medical group membership is practically a prerequisite to obtaining an MCO contract, physicians of color face substantial barriers to entering such groups. Often, they are unable to buy their way into medical groups that both have startup costs and ask all physicians to share in those costs.[81] Because these physicians disproportionately serve a poorer and usually sicker clientele, they are not as well compensated as white doctors. Medicaid payments account for 24.6 percent of black physician revenues, yet Medicaid, on average, pays only 47 percent of what private insurers pay.[82] In some cases, medical groups are formed by buying the practices of individual physicians.[83] Because minority physicians serve poorer and sicker patients, and provide more charity care, the cost of maintaining their practices is higher and the revenues lower, which likely deters medical groups from making offers to buy such practices.[84]

78. *See* Mark A. Hall, *Managed Competition and Integrated Health Care Delivery Systems*, 29 WAKE FOREST L. REV. 1, 4-5 (1994).

79. *See* Mackenzie, *supra* note 47 at 1255 (using survey shows that physicians in solo practice, as compared to physicians in group practice, report significantly more problems securing contracts and report more severe problems with not being able to secure enough contracts).

80. *See* Joint Center for Political and Economic Studies, *Can Black Doctors Survive? Managed Care, Cuts in Training, and Attacks on Affirmative Action Threaten to Reduce the Ranks of Black Physicians*, *available at* http://www.jointcenter.org/publications1/focus/FocusDetail.php?recordID=44.

81. *See* Starr, *supra* note 18.

82. *See* Joint Center for Political and Economic Studies, *supra* note 80; Sidney Watson, *Commercialization of Medicaid*, 45 ST. LOUIS. U. L.J. 53, 56 (2001).

83. *See* Starr, *supra* note 18.

84. *See* Joint Center for Political and Economic Studies, *supra* note 80.

More frequently, however, many physicians of color choose to practice solo. Some fear that practicing in a group will cut them off from their patients because there is no obligation to accept Medicaid and many large medical groups refuse to accept Medicaid patients because of financial and "other" reasons.[85] Other minority physicians point to the lingering suspicion that majority-dominated medical groups will subordinate physicians of color, limiting their role in management decisions and policy-making.[86] Some indicate that despite ethical obligations of equality, medical groups are often hostile to the inclusion of minority physicians.

Speaking before the North Carolina Legislative Black Caucus in June 2002, Dr. Ron Virmani described the continuing existence of the "good old boy" network in medicine:

> The big white medical groups import newly graduated white residents from far-flung cities and ignore those of us seeking association and opportunity. When this pattern of exclusion becomes too obvious, they take in a token number of African Americans and other politically active minorities. This move is calculated to douse any fire of criticism that may be gaining in intensity.[87]

While MCOs may have very good reasons for preferring providers affiliated with medical groups, this selection criterion implicitly devalues the quality of care provided by minority solo practitioners. This practice is also insensitive to both the historical and contemporary role of race and ethnicity in determining medical group composition.

C. Board Certification

A final hurdle is the nearly universal requirement that participating physicians be board-certified, that is, that they have passed an examination by a medical specialty board.[88] Board certification is not a requirement for practicing medicine in this

85. *See* Sara Rosenbaum et al., *U.S. Civil Rights Policy and Access to Heath Care by Minority Americans: Implications for a Changing Health Care System*, 57 MED. CARE RES. & REV. 236, Suppl. 1, (2000).

86. *See* Starr, *supra* note 18.

87. Ron A. Virmani, *Discrimination in U.S. Medicine*, presented at the 17th Annual Legislative, Educational and Weekend Conference sponsored by the North Carolina Legislative Black Caucus Foundation, Inc., (June 22, 2003) (copy on file with author).

88. *See* Troyan Brennan et al., *The Role of Physician Specialty Board Certification Status in the Quality Movement*, 292 JAMA 1038 (2004).

country, and some MCOs use board certification mainly as a marketing tool.[89]

Board certification rates differ along racial lines. An estimated 79 percent of white physicians are board-certified compared to 68 percent of black physicians.[90] One reason for the disparity is that most black physicians are primary care physicians.[91] Board certification for primary care physicians is a relatively new phenomenon and minority physicians have been reluctant to undergo the extra years of training and additional costs.[92]

Serving minorities and the poor is not a skill that can be measured through a written exam. It requires a special understanding of the environment and culture as well as special communication skills and sensitivities that come from being accepted in that environment. Most of the minority physicians practicing in these communities are board qualified, and according to some, there is little to gain from taking the examinations except an additional certificate that their patients care little about.[93]

D. Minority Health

Flawed assessments of physician quality and efficiency have serious implications for minority health. MCOs may overlook talented minority physicians who know the community and understand their symptoms and needs.

Statistical trends show a persistent, distressing disparity in key health indicators among minority populations relative to the overall population.[94] For instance, the African-American community carries a greater burden of illness, particularly diabetes, cancer, heart disease, infant mortality, and HIV/AIDS, than does the majority white population.[95] In addition, a growing body of

89. *See* Jay Greene, *Certification Woes: No Boards, No Income*, Pinnacle Health Group News, July 31, 2000 (reporting that the industry acknowledges that some MCOs require board certification as a marketing tool), *available at* http://www.phg.com/article_a005.htm.

90. *See NewsHour*, *supra* note 15.

91. *See* AMERICAN MEDICAL ASSOCIATION, *supra* note 4, at 41.

92. *All Things Considered: Minority Doctors Say They Can't Get Into HMOs* (National Public Radio Broadcast, Nov. 14, 1996) (transcript at 4).

93. Interview with Kimkiya Asika, Old North State Medical Association, (August 5, 2004).

94. *See* Centers for Disease Control and Prevention, *Health Disparities Experienced by Black or African Americans – United States*, 54 Mortality Morbidity Weekly Rev. 1-3 (Jan. 14, 2005), *available at* http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5401a1.htm.

95. *Id.*

compelling evidence points to differential medical treatment for similarly situated minority and white patients.[96] Black patients are less likely to receive cardiovascular care, cancer screening, HIV therapy, and a host of other medical and surgical procedures, even after adjustments are made for clinical condition, insurance, education, and income.[97]

Patients of color commonly prefer health care from clinicians of the same racial and ethnic background,[98] and report greater satisfaction, trust, and better physician relationships when the health care system satisfies this preference. Some studies show that they also have better outcomes. In 1999, two studies examined how race affects the medical visit. In a JAMA study published that year, researchers at the Johns Hopkins School of Public Health reported that patients in same-race relationships rated their physicians' decision-making styles as significantly more participatory than patients in race-disconcordant relationships.[99] Minority patients had significantly less partnership building relationships with white physicians regardless of patient education level. This finding suggests that racial and ethnic differences, rather than socioeconomic differences, serve as more important communication

96. In 1999 Congress instructed the Institute of Medicine to prepare a report on racial disparities in health care. The study committee performed a literature review of articles in the PUBMED and MEDLINE databases published in peer-reviewed journals from 1992 to 2002. To be selected, the articles must have addressed racial differences in health care while controlling for access and a range of other potential confounding variables. Over one hundred studies were selected and summarized. *See* Institute of Medicine, UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 30 (Brian D. Smedley et al., eds., 2003). *See also* Rene Bowser, *Racial Profiling in Health Care: An Institutional Analysis of Medical Treatment Disparities*, 7 MICH. J. RACE & L. 80, 83-89 (2001); M. Gregg Bloche, *Race and Discretion in American Medicine*, 1 YALE J. HEALTH POL'Y L. & ETHICS 95 (2001); Gwendolyn Roberts Majette, *Access to Health Care: What a Difference Shades of Color Make*, 12 ANNALS HEALTH L. 121 (2003); Barbara A. Noah, *Racial Disparities in the Delivery of Health Care*, 35 SAN DIEGO L. REV. 135 (1998); Sidney D. Watson, *Race, Ethnicity and Quality of Care: Inequalities and Incentives*, 27 AM. J.L. & MED. 203 (2001); Sidney D. Watson, *Race, Ethnicity and Hospital Care: The Need for Racial and Ethnic Data*, 30 J. HEALTH & HOSP. L. 125 (1997).

97. *See* Institute of Medicine, *supra* note 96, at 25-61.

98. For instance, On April 5, 2005, a Harlem-based physician launched a new website devoted to matching African Americans with black physicians. The free internet service allows the public to locate U.S.-based African-American physicians, as well as dentists, podiatrists, clinical psychologists, and other health care providers. According to its founder, the idea for the service grew out of the strong demand expressed by African Americans to locate and be treated by physicians of the same race. *See Find a Black Doctor*, http://www.findablackdoctor.com.

99. Lisa Cooper-Patrick et al., *Race, Gender, and Partnership in the Patient-Physician Relationship*, 282 JAMA 583 (1999). For example, compared to white patients, black patients visiting white physicians were significantly less likely to rate their visits as participatory. *Id* at 587.

barriers between patients and physicians.[100]

Also in 1999, another study reported that black patients paired with black physicians were much more likely than those paired with white physicians to rate their physicians as excellent overall, excellent at treating them with respect, explaining problems, listening, and being accessible to them.[101] In addition, black patients paired with black physicians reported receiving more preventive care and other necessary medical care.[102] Latino/a patients paired with Latino/a physicians likewise reported greater satisfaction.[103] In 2001, Oliver and colleagues reported that white physicians, on average, spend less time with African-American patients than with white patients on planning treatment decisions, providing health education, chatting, assessing patients' health knowledge, and answering questions.[104]

In 2004, researchers listened in on examining rooms for clues as to why minorities tend to receive lower quality health care than whites, even when they have equal access and ability to pay.[105] They found that physicians tend to do more of the talking during examinations when patients are black; indeed physicians talked 43 percent more than their black patients compared to 24 percent more than their white ones.[106] The emotional tenor of conversations, on the part of both patients and physicians, was more likely to be positive when patients were white.[107] Black patients and their doctors sounded less interested, engaged, and friendly, compared with conversations between white patients and their physicians. [108]

Professor Dorothy Roberts suggests that the experience of both racism and sexism profoundly affects the medical visit for women of color.[109] She explains that the political dimension of doctor-patient communications is more apparent when the patient is a woman of color and suggests that women of color may be more willing to resist medical supervision because they are more suspicious of

100. *Id.* at 588.

101. *See* Somnath Saha et. al., *Patient-Physician Racial Concordance and the Perceived Quality and Use of Health Care*, 159 ARCHIVES INTERNAL MED. 997, 997-98 (1999).

102. *Id.* at 1002.

103. *Id.* at 1000.

104. Milton Oliver et al., *Time Use in Clinical Encounters: Are African-American Patients Treated Differently?*, 93 J. NAT'L. MED ASS'N. 380 (2001).

105. *Id.*

106. *See* Rachel Johnson et al., *Patient Race/Ethnicity and the Quality of Patient-Physician Communication During Medical Visits*, 94 AM. J. PUB. HEALTH 2084 (2004).

107. *Id.* at 2085-86.

108. *Id.*

109. *See* Dorothy E. Roberts, RECONSTRUCTING THE PATIENT: STARTING WITH WOMEN OF COLOR, IN FEMINISM AND BIOETHICS 116, 117 (Susan M. Wolf ed., 1996).

doctors' claims of beneficence.[110]

Research indicates that patient outcomes improve when provider and patient are of the same racial and ethnic background. When patients and providers speak the same native language, patients are more likely to report positive physical and mental health outcomes.[111] Conversely, patients' inability to communicate in their native language leads to delays in care, fewer or missed appointments, and non-adherence to treatment.[112] Medical error frequently occurs when physicians can't understand the health complaints of patients with limited English proficiency.[113] Language aside, there is limited empirical evidence that race concordance directly improves patient outcomes because studies have not been done in this area.[114] Generally, positive physician-patient communication and participatory decision-making (both associated with race concordance), have been linked to better outcomes. With this in mind, there are good reasons to believe that race concordance is also associated with improved outcomes.

Increasing the supply of minority physicians is critical to improving healthcare in minority communities. Minority physicians' understanding of the cultural, social, and economic issues present in minority communities is essential to providing appropriate, high-quality services to this population. Another reason the health status of blacks, Latinos/as and Asian-Americans is so dependent on the availability of minority physicians is that these doctors are much more likely than their white colleagues to locate their practices in areas with large minority populations, areas that are usually medically underserved as well. Selection and de-selection practices that reduce the number of physicians available to minority groups will increase the likelihood that minorities will continue to have less access to health care than others and continue to have poorer health.

110. *Id.* Professor Roberts also points out that women of color are more willing to reject their doctor's orders, as well as the dominant medical language.

111. *See* Eliseo J. Perez-Stable et al., *The Effects of Ethnicity and Language on Medical Outcomes of Patients with Hypertension or Diabetes*, 35 MED. CARE 1212, 1213 (1997).

112. *See, e.g.*, Kathryn Pitkin Derose & David W. Baker, *Limited English Proficiency and Latinos' Use of Physician Services*, 57 MED. CARE RESEARCH REV. 76 (2000); Aaron Manson, *Language Concordance as a Determinate of Patient Compliance and Emergency Room Use in Patients with Asthma*, 26 MED. CARE 1119 (1988); Sherry Riddick, *Improving Access for Limited English Speaking Consumers: A Review of Strategies in Health Care Settings*, 9 J. HEALTH CARE POOR & UNDERSERVED 40 (1998).

113. *See* Perez-Stable, *supra* note 111, at 1213.

114. *See* Robert Rosenheck et al., *Effect of Clinician-Veteran Racial Pairing in the Treatment of Posttraumatic Stress Disorder*, 152 AM. J. PSYCH. 555 (1995).

III. The Medical Professions' Third World: Discrimination and Physicians of Color

The early periods of the U.S. health care system set a tone, which resonates today, that America's health care professions were to be dominated by a white elite. Black health care professionals - including physicians, dentists and nurses - were banned from the nation's professional health schools.[115] The *Plessy v. Ferguson* decision and the subsequent wave of Jim Crow legislation confined the opportunities available to black physicians - restricting the supply, limiting the ability to serve minority communities, and excluding black physicians from powerful professional organizations that shaped health care policy.[116]

Historical patterns of segregation both within the medical profession and society shaped physician practice patterns and continue to influence where physicians practice, how they organize their practices, and what patients they see. The continuity of the "good old boy" network may play a role in determining which physicians are recruited and selected. According to Bindman, "[m]anaged care networks may develop around existing informal physician networks based on traditional referral patterns and social arrangements and may perpetuate segregated arrangements."[117] Elizabeth Mackinzie also stresses the important role of informal networks in acquiring contracts and their marginalizing effect on minority physicians.[118]

A. Barriers to Medical Education and Training

Because of the color line, the first few black physicians received their medical degrees abroad.[119] In 1849, Oliver Wendell Holmes Sr.

115. *See, e.g.*, W. Michael Byrd & Linda A Clayton, AN AMERICAN HEALTH DILEMMA: RACE, MEDICINE AND HEALTH CARE IN THE UNITED STATES 1900-2000 (Routledge 2002).

116. *See* DAVID BARTON SMITH, HEALTH CARE DIVIDED: RACE AND HEALING A NATION 14 (University of Michigan Press 1999). Blacks developed a separate medical education system. Under AMA pressure, access to the medical profession increasingly required a college degree followed by medical school; both avenues were less available to blacks. Black colleges were the natural response, including the two leading black medical schools, Howard in Washington and Meharry in Nashville. *See* W. Montague Cobb, *Surgery and the Negro Physician: Some Parallels in Background*, 43 J. NAT'L MED. ASS'N 145, 150-51 (1951).

117. *See* Andrew Bindman et al., *Selection and Exclusion of Primary Care Physicians by Managed Care Organizations*, 279 JAMA 675, 675 (1998).

118. *See* Mackenzie, *supra* note 47, at 1261.

119. JAMES L. CURTIS, BLACKS, MEDICAL SCHOOLS, AND SOCIETY (University of

admitted three blacks to the Harvard Medical School.[120] In response, the students passed and forwarded to the medical faculty resolutions opposing the admissions because they believed the presence of blacks would cheapen the Harvard medical degree, diminish the quality of education and would be socially offensive.[121] Professor Holmes acquiesced to student demands and dismissed the admitted students.[122] In 1860, only nine northern medical schools admitted blacks; southern medical schools were completely closed. In 1905, there were 1,465 black physicians; only 14.5 were graduates of white institutions.[123] By 1950, blacks were 10 percent of the population, but only 2.2 percent of all physicians,[124] and only 133 blacks graduated from medical school, mostly from the two black institutions—Meharry (Nashville) and Howard (Washington, D.C.).[125]

More than a decade after the 1954 *Brown* decision, neither the medical profession nor the medical education system had responded enthusiastically to the demand for racial integration. Overt discrimination against black medical students persisted well into the 1960s; the first southern medical school to admit blacks was the University of Arkansas in 1948.[126] It was not until 1967 that the last southern medical school admitted a black medical student.[127] In 1971, the first year for which there are data on minority groups other than blacks, only 19 Mexican Americans, 14 mainland Puerto

Michigan Press 1971).

120. *See* Harry M. Delany, *Affirmative Action and Diversity in the Medical Profession*, 20 EINSTEIN J. BIOLOGICAL MED. 78, 79 (2004).

121. *Id.* at 78-79.

122. *Id.* at 78. Blacks faced discrimination in gaining acceptance to law and other professional schools, but the exclusion of blacks from white medical schools was singular because it implicated social taboos and customs prohibiting interracial touching. For instance, Audre de Lambart Maynard, a prominent New York physician most noted for saving Dr. Martin Luther King Jr.'s life after a near fatal stabbing in 1958, applied to and was accepted by the College of Physicians and Surgeons of Columbia University in 1922. After enrolling, the dean informed Maynard that after his first two years at Columbia it would be best for him to transfer to Howard for his clinical years because of the "embarrassment" likely to arise if he carried out certain examinations on white patients.

123. *See* HERBERT M. MORAIS, THE HISTORY OF THE NEGRO IN MEDICINE 60 (New York Publishers Co. 1970).

124. *See* DIETRICH C. REITZES, NEGROES AND MEDICINE xxvii (Harvard University Press 1958).

125. *A JBHE Check-Up on Blacks in U.S. Medical Schools*, J. OF BLACKS IN HIGHER EDUC., July 18, 2005, *available at* http://www.jbhe.com/features/47_medicalschools.html.

126. *See* Paul Cornely, *Segregation and Discrimination in Medical Care in the United States*, 46 AM. J. PUB. HEALTH 1074 (1956).

127. EDWARD H. BEARDSLEY, A HISTORY OF NEGLECT: HEALTH CARE FOR BLACKS AND MILL WORKERS IN THE TWENTIETH-CENTURY SOUTH 255 (University of Tennessee Press 1987).

Ricans, and 2 Native Americans graduated from U.S. medical schools.[128]

Blacks faced similar exclusion from most medical internship and residency programs, prerequisites for obtaining a medical license to practice, regardless of their medical school achievements.[129] Blacks wanting to obtain postgraduate training were expected to pursue it at one of the black hospitals; however, not all black hospitals welcomed them.[130] Indeed, white-sponsored hospitals that served black patients were often hostile to the advancement of black physicians.[131]

B. AMA Exclusion

Paul Starr chronicled the rise of medicine as a profession from the 1850s, and the growing power of the American Medical Association (AMA),[132] but black physicians were largely excluded from the AMA and its constituent societies.[133] This professional discrimination had disastrous consequences for African-American patients, who had only black physicians to work for their interests in the health care system.[134]

Historically, the AMA ignored the equality demands of black physicians, overtly discriminated against them, and refused their

128. Herbert Nickens et al., *Project 3000 by 2000: Racial and Ethnic Diversity in U.S. Medical Schools*, 331 NEW ENGL. J. MED. 472, 472-73 (2004).

129. PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (Greenwood 1982).

130. *See* VANESSA N. GAMBLE, MAKING A PLACE FOR OURSELVES: THE BLACK HOSPITAL MOVEMENT, 1920-1945 31 (Oxford University Press 1995).

131. *Id.* at 31-32. When segregated hospitals were available to blacks, they were often used for training white physicians, residents and interns. *See* H.M. Green, *Hospitals and Public Health Facilities for Negroes*, 1928 PROC. OF THE NAT'L CONF. OF SOC. WORK 179, 179-80 (1928) ("Many cities, especially in the South, provide wards, usually in the basement of their city hospitals, for Negro patients. A few northern cities admit Negro patients to their free wards along with their white paupers. These institutions invariably exclude Negro physicians. Here the Negro patients (North and South) are used largely as clinical material for training internes [sic] of another race, a practice employed by no other civilized country in the world.").

132. STARR, *supra* note 129.

133. Although black physicians appreciated the virtues of professionalism in medicine, the color line prevented them from obtaining what other groups gained from professionalism: the institutionalization and advancement of a specialized body of knowledge; the development of educational institutions to further this knowledge; the development and enforcement of a professional code of ethics; as well as the solidarity, security and fellowship valued by all members of any profession. *See* Byrd & Clayton, *supra* note 115.

134. *Id.*

efforts of professional participation at all levels. Black physicians created the National Medical Association NMA in 1895 only after they had waged a long and unsuccessful effort to integrate the AMA.[135] From the beginning, the NMA and the AMA were often completely opposed in philosophy and ideology regarding health needs, health care services, health policy and the health rights of disadvantaged populations.[136]

C. Hospital Admitting Privileges

State and local medical associations prevented vitally needed access to hospitals, excluding minority physicians from hospital appointments and hospital admitting privileges.[137] The medical-staff bylaws of most hospitals in the United States required that physicians applying for hospital admitting privileges be a member in good standing of the local county medical society.[138] At the same time, the bylaws of most state medical societies explicitly restricted membership to white physicians.[139] Because county medical societies were constituent members of the state body, the race restriction applied at the local level.[140] This system of racial subordination forced physicians of color to turn over care of their hospitalized patients to white physicians; those fortunate enough to gain admitting privileges were frequently forced to work under the supervision of white physicians.[141]

These racially discriminatory practices badly undermined confidence in black physicians and contributed to a perception that

135. *Id.* Black physicians also created local medical societies such as the Tennessee Colored Medical Association (1880): the Medico-Chirurgical Society of the District of Columbia (1884); the Lone Star State Medical Association (1886); the Old North State Medical Society of North Carolina (1887), the Association of Physicians, Dentists, and Pharmacists in Georgia (1893); the Association of Physicians, Dentists, and Pharmacists in Georgia (1893); and the Alabama Medical, Dental and Pharmaceutical Association (1896).

136. In medical education, for example, the AMA saw a clear place for black physicians. Their education should be focused on the principles of hygiene, rather the techniques of surgery, and their usefulness as physicians should be focused on preventing the spread of tuberculosis and other infectious diseases from black populations to white populations. *See* ABRAHAM FLEXNER, MEDICAL EDUCATION IN THE UNITED STATES AND CANADA (Carnegie Foundation for the Advancement of Teaching 1910).

137. *See* Cornely, *supra* note 126, at 1077-78 (discussing role of AMA and its constituent societies in denying hospital admitting privileges to black physicians).

138. *Id.*

139. *Id.*

140. *Id.*

141. *See* GAMBLE, *supra* note 130, at 12.

they were less competent than their white peers.[142] The devaluing of black physicians has proven strongly resistant to change. For instance, in a little-noted remark to the *New York Times* in 1997, Ward Connerly, the leader in the fight against California's racial bookkeeping and preferences, quipped: "If you're lying on a gurney, and a black doctor shows up, you're going to get up and crawl out."[143]

In 1938, the NMA, struggling to obtain hospital admitting privileges for its members approached the AMA with three requests: (1) recognize NMA membership as sufficient qualification for AMA membership, thereby circumventing the white-only medical societies; (2) eliminate the racial identification of black physicians who were AMA members in the AMA directory (black members were identified with "Col." appearing after their names); (3) support the admission of black physicians to staff privileges at tax-supported hospitals. The AMA agreed to the second request only, and dropped all racial designation from the AMA directory in 1940.[144]

Overt discrimination against black physicians in the south persisted well into the 1960s, with the AMA issuing non-binding proclamations of non-discrimination, but refusing to challenge discriminatory practices by its local and state constituent medical societies.[145] In 1966, the AMA House of Delegates again defeated a resolution that would have expelled from the AMA constituent societies that engaged in discriminatory practices.[146]

D. Government Sanctioned Discrimination

The federal government placed its imprimatur on physician discrimination under the Hill-Burton Act of 1946.[147] Segregationist

142. *Id.*

143. *See* Barry Bearak, *Between Black and White – A Special Report: Questions of Race Run Deep for Foe of Preferences*, N.Y. TIMES, July 27, 1997, § 1, at 3.

144. *See* SMITH, *supra* note 116.

145. The AMA passed weak resolutions in 1950 and 1952, but did nothing to prevent its local and state medical societies from excluding blacks from membership, with full knowledge that such membership was necessary to be appointed to the medical staffs of most hospitals. *See* MORAIS, *supra* note 123, at 152-53, 175, 224. For instance, a 1950 resolution urged that "constituent and component societies that have restrictive membership provisions based on race study this question in light of prevailing conditions, with the view to taking steps as they may elect to eliminate such restrictive provisions." AMERICAN MEDICAL ASSOCIATION, Resolution on Restrictive Membership Provisions, 143 JAMA 1086 (1950).

146. *See* SMITH, *supra* note 116, at 73-74.

147. Hospital Survey and Construction Act, Pub. L. No. 79-725, 60 Stat. 1040 (1946).

Senator Lester Hill carefully designed the statute to permit "separate but equal" facilities.[148] Of 7000 Hill-Burton projects funded before 1970, only 104 were racially inclusive, including 84 white facilities and 20 black facilities.[149] The National Medical Association opposed the Hill-Burton "separate but equal" provisions.[150]

Black physicians sought relief from the federal courts. *Simkins v. Moses H. Cone Memorial Hospital,*[151] involved the Moses H. Cone Memorial Hospital and the Wesley Long Community Hospital of Greensboro, North Carolina, which had received substantial federal funds under Hill-Burton.[152] Both hospitals had formal policies that denied staff privileges to black physicians and dentists.[153]

The court of appeals held that the refusal to grant staff privileges to black doctors discriminated against them in violation of the equal protection clause of the Fourteenth Amendment, finding that the hospitals' receipt of federal construction money constituted state action.[154] The *Simkins* court also held that the Hill-Burton "separate but equal" provisions were unconstitutional.[155]

Congress passed Title VI of the 1964 Civil Rights Act,[156] in part, to ensure that federal money could no longer be used to support discrimination in health care. The AMA and NMA differed sharply on the implementation of Title VI in health care. The NMA wanted a close watch of all health facilities and supported the collection of provider and patient race information.[157] The AMA opposed the collection of data on the race of hospital staff physician members,

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For a legislative history of Hill-Burton, see Congressional Quarterly, Inc., *Hill-Burton Hospital Survey and Construction Act, 1946,* in CONGRESS AND THE NATION 1945-1964 1122-23 (1965). Under the Hill-Burton program, federal and state governments assisted in the planning and construction of thousands of hospitals and other health facilities across the United States, most of which continued their existing patterns of discrimination and segregation untroubled by the receipt of federal funds. *See* Morais, *supra* note 123, at 152.

148. *See* SMITH, *supra* note 116, at 46-47.

149. *See* MORAIS, *supra* note 123, at 181.

150. *Id.* at 152.

151. 323 F.2d 959 (4th Cir. 1963) (en banc), *cert. denied,* 376 U.S. 938 (1964).

152. *Id.* at 960.

153. *Id.*

154. *Id.* at 967-68.

155. In Eaton v. Grubbs, 329 F.2d 719 (4th Cir. 1964), plaintiffs alleged that the James Walker Memorial Hospital in Wilmington, North Carolina, denied staff privileges to black physicians. The court of appeals found that sufficient "state action" was present to make the protections of the Fourteenth Amendment applicable, and reversed the district court's dismissal of the complaint.

156. Pub. L. No. 88-352, 78 Stat. 252 (codified at 42 U.S.C. § § 2000d-2000d-4 (1982)).

157. *See* MORAIS, *supra* note 123, at 197.

labeling this method of enforcement a "race quota system."[158]

In 1965, President Lyndon Johnson connected Medicare funding with Title VI compliance.[159] In doing so, President Johnson risked a boycott of the fledgling health care program. The lure of federal funds, together with Johnson's political skills, ultimately convinced physicians and hospitals to participate in Medicare, although physicians were exempted from the proscriptions of Title VI.[160] The NMA supported the linkage of Medicare and Title VI,[161] while the AMA opposed Medicare altogether and undertook a massive campaign to portray Medicare as "socialized medicine."[162]

Even though *de jure* discrimination was over, it quickly became evident that old habits die hard. To keep minority physicians out, hospitals employed a variety of tactics such as secrecy and abuse of due process. *Cypress v. Newport News General and Nonsectarian Hospital Ass'n*,[163] involved discrimination at the Riverside Hospital in Newport News, Virginia. The plaintiff was a board-certified pediatrician who had met all the requirements of the American Board of Pediatrics for certification in that specialty.[164] Dr. Cypress had applied for staff privileges on two separate occasions, and been rejected twice.[165] There were only seven pediatricians in the community – six of them were white, and all of the white pediatricians had been given staff privileges.[166]

Another black physician, Dr. C. Waldo Scott, was a board-certified surgeon. He, too, applied for staff privileges and was denied.[167] There were 18 white surgeons in the community, only half of them board certified. Seventeen of them had been given staff privileges by the hospital.[168] Medical experts in the fields of Dr. Cypress' and Dr. Scott's specialties testified that their professional qualifications and skills were outstanding.[169] The Court of Appeals

158. *Id.* at 197.

159. *See* SMITH, *supra* note 116.

160. *See* Sidney D. Watson, *Race, Ethnicity and Quality of Care: Inequalities and Incentives*, 27 AM. J.L. & MED. 203, 214 (2001).

161. Hearings on H.R. 6675 Before the S. Fin. Comm., 89th Cong. 323-28 (1965) (statement of Dr. W. Montague Cobb, President of the National Medical Association).

162. *See* STARR, *supra* note 129, at 368.

163. 375 F.2d 648 (4th Cir. 1967).

164. *Id.* at 651.

165. *Id.*

166. *Id.* at 652.

167. *Id.*

168. *Id.*

169. One expert was a Professor Emeritus at Harvard Medical School, former Chief of Children's Services at Massachusetts General Hospital, and past President of the American Pediatric Association. He not only reviewed the paper credentials of Dr. Cypress, but also directly observed him while Dr. Cypress was treating patients. He testified that he would be glad to recommend Dr. Cypress for appointment to the

granted injunctive relief under Title VI.[170]

Racial discrimination and differential treatment within the medical profession reemerged as a major problem in the 1980s. Allegations that white-run hospitals were purging black physicians from hospital staffs surfaced in Detroit, Chicago, Forth Worth, and Houston, among other places.[171] The charge was that under the guise of "quality assurance" professional peer review was being used in a racially discriminatory manner to drive out physicians of color.[172] In 1986, Dr. W. Michael Byrd, a leading figure in the fight for medical civil rights, urged Congress not to enact legislation that would immunize members of peer review committees from civil actions:

> In reference to black doctors, there is presently a purge taking place in the profession. The hospital staff disciplinary process is one of the major mechanisms of carrying this out. This new wave of discrimination taking place in the nation's hospitals is easy to document. The National Medical Association, the National NAACP, and the Office of Civil Rights consider the problem "an epidemic." To arm white organized medicine and the medical-industrial complex with more tools to discriminate is analogous to giving Jack the Ripper a new machete or even a machine gun. This certainly would enhance their "kill power." How did this state of affairs evolve in our republic founded on the teachings of Locke, Rousseau, Montesquieu, where common citizens aren't libel to "Spanish Inquisitions," and doctors are?[173]

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pediatric staff of Massachusetts General Hospital. *Id.* at 660.

Another witness was the Health Director of Newport News, and former commanding officer of the Fort Eustis, Virginia Army Hospital where Dr. Cypress had been employed as a civilian pediatrician. He testified: "Well, in my twenty-nine years of practice of medicine, I have never been associated with a better pediatrician than Dr. George C. Cypress and I would recommend him for any staff." *Id.*

The Director of Surgery at Morrisania Hospital in New York, who was also a Professor of Clinical Surgery at New York University and Bellevue Medical Center, testified from his observation of Dr. Scott that "he had almost . . . flawless technique" and was technically "well above average." He would be happy to have a man of Dr. Scott's caliber at his hospital "as an example for a group of residents not only about how to do surgery" but about other things as well. *Id.* at 660-61.

170. *Id.* at 665.

171. *See* Byrd & Clayton, *supra* note 115, at 415.

172. *Id.*

173. *Health Care Quality Improvement Act of 1986: Hearing on H.R. 5540 Before the Subcomm. on Civil and Civil and Constitutional Rights of the H. Comm. on the Judiciary*, 99th Cong. 2 (1986) (statement of W. Michael Byrd).

IV. Federal Civil Rights Laws and Legislative Reform

It may prove difficult to use existing civil rights laws to address the exclusion of minority providers from managed care. This section analyzes the legal and practical difficulties of prevailing under Title VII and Title VI of the Civil Rights Act of 1964. Finding these civil rights remedies lacking, this article proposes that congress modify existing provisions of the Social Security Act to require the collection of race and ethnicity data by MCOs receiving funding under Medicare and Medicaid.

A. Title VII

Title VII[174] ensures equal opportunity of employment and may not be well suited to address racial discrimination in the medical market. Under many managed care organizational arrangements, minority physicians would likely be considered independent contractors, a class not protected under Title VII, which only addresses discrimination in the employer-employee relationship.[175] Only physicians in staff model HMOs, who usually sign employment contracts with the HMO and receive a salary from the HMO, seem clearly protected under Title VII. Courts holding that independent contractors are not protected may still find coverage based on an employers' exercise of significant control over the independent contractor's business.[176]

Surprisingly little case law applies the "control test" to the MCO/physician-contractor relationship. In one of the few reported cases, *Petrovich v. Share Heath Plan of Illinois*,[177] the court held that the MCO's use of capitation as a method of payment, its quality assurance program and its use of primary care physicians as gatekeepers were sufficient to defeat Share's summary judgment motion on the issue of whether it controlled the manner in which physicians worked.[178] It is equally likely, however, that other courts

174. Civil Rights Act of 1964, 42 U.S.C. § 2000e-2000e-17 (2003).

175. *Id.* § 2000e-2 (prohibiting employers from discriminating against any individual or from classifying any individual on the basis of race, color, religion, sex, or national origin). The statute defines an employer as any entity with more than fifteen persons engaged in an industry affecting commerce. *Id.* § 2000e(b).

176. *See* Vahharia v. Swedish Covenant Hosp., 109 F.3d 799 (7th Cir. 1999) (finding a hospital anesthesiologist was an independent contractor); Wortham v. Am. Family Ins. Group, 385 F.3d 1139 (8th Cir. 2004) (finding an insurance agent was an independent contractor).

177. 513 N.E.2d 833 (1999).

178. *Id.* at 25.

would view these same features as a means to control the details, rather than the methods of work.

Even assuming that a minority physician can show that she is covered under Title VI, without direct evidence of discrimination, the aggrieved physician would have to prove a disparate impact claim.[179] Establishing a prima facie case would be very difficult for two reasons. First, statistical evidence is usually required to demonstrate that an inordinately high number of qualified minority physicians were excluded because of the selection and de-selection criteria. However, MCOs do not collect racial and ethnic provider data. Second, the MCO could easily rebut the presumption of discrimination by proving that the selection and de-selection criteria are consistent with business necessity.[180] MCOs asserting that these criteria are vital to ensuring cost-effective and high quality care would likely prevail.

B. Title VI

Title VI of the Civil Rights Act of 1964[181] has served as the primary legal tool for redressing discrimination in health care. Title VI prohibits recipients of federal financial assistance, including hospitals, nursing homes, and doctors who accept Medicaid or Medicare from discriminating on the basis of race, color, or national origin.[182] The statute prohibits intentional discrimination and its implementing regulations prohibit facially neutral policies and practices that have a disproportionately adverse impact on minorities, even in the absence of discrimination.[183]

179. To establish a prima facie case of disparate impact under Title VII, the plaintiff must show that a challenged employment practice caused a statistical disparity with respect to the number of protected class members in the workforce in comparison to the number of protected class members in the relevant labor market. In other words, a plaintiff must demonstrate not only the disparity but also that the disparity is a result of the employment practice in question. *See, e.g.*, Steward v. Gwaltney of Smithfield Ltd., 954 F. Supp. 1118 (E.D. Va. 1996), *aff'd*, 103 F.3d 120 (4th Cir. 1996).

180. Title VII requires a defendant to prove the legitimacy of the challenged criteria. *See* 42 U.S.C. § 2000e-2(k)(1)(A). If a defendant succeeds in demonstrating the legitimacy of its selection criteria, an excluded minority physician still may prevail if she can prove that the defendant's explanation is merely a pretext for the discriminatory business practice. *See id.* at 660-61.

181. *See* 42 U.S.C § 2000d-2000d-4 (2003).

182. *See id.*

183. These regulations prohibit "criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program as respect individuals of a particular race, color, or national

A Title VI approach is complicated by the fact that the Department of Health and Human Services has not provided any guidance as to whether Title VI applies to MCOs. State court decisions discussing tort liability of MCOs are instructive. In recent years, some courts have held that MCOs are subject to the same duty of care as hospitals. In *Shannon v. McNulty*, the court applied the corporate negligence doctrine applicable to hospitals to an HMO, emphasizing that MCOs perform the same or similar function as hospitals.[184] Other courts also view MCOs as functionally similar to hospitals.[185] These decisions provide some support for viewing MCOs as hospitals for Title VI purposes. Thus, if an MCO participates in Medicare or Medicaid through one of its product lines, it presumably would be considered a recipient of federal funds and its health care operations presumably subject to civil rights oversight.

Assuming that a minority physician can prove that she is protected under Title VI, she may have considerable difficulty proving a Title VI claim. In an intentional discrimination claim, the plaintiff must prove motive.[186] In a claim alleging disproportionate adverse impact, the plaintiff must identify a particular racially neutral policy or practice that has a statistically significant adverse effect on a protected racial or ethnic group.[187] Once the plaintiff establishes this prima facie case, the burden shifts to the defendant to justify the challenged practice by establishing a legitimate, nondiscriminatory reason for the policy or practice.[188]

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origin. *See* 45 C.F.R. § 80.3(b)(1)(vii)(2) (2002). For a history of the case law upholding these regulations, see Sidney D. Watson, *Reinvigorating Title VI: Defending Health Care Discrimination – It Shouldn't Be So Easy*, 48 FORDHAM L. REV. 939, 948-55 (1990).

184. In *Shannon*, 718 A.2d 828 (Pa. Super. Ct. 1998), the court emphasized:

> [W]e recognize the central role played by HMOs in the total health care of its subscribers. A great deal of today's healthcare is channeled through HMOs with the subscribers being given little or no say so in the stewardship of their care. Specifically, while these providers do not practice medicine, they do involve themselves daily in decisions affecting their subscriber's medical care. These decisions may, among others, limit the length of hospital stays, restrict access to therapy, or prevent rendering of emergency room care . . . Where the HMO is providing health care services rather than merely providing money to pay for services their conduct should be subject to scrutiny. We see no reason why the duties applicable to hospitals should not be equally applied to an HMO when that HMO is performing the same or similar functions as a hospital. *Id.* at 832

185. *See* Boyd v. Albert Einstein Med. Ctr., 547 A.2d 1229 (Pa. Super. Ct. 1988).

186. *See* Elston v. Talladega County Bd. of Educ., 997 F.2d 1394, 1407 (11th Cir. 1993).

187. *See* Watson, *supra* note 183, at 948-49.

188. *See Elston*, 977 F.2d at 1407 (holding that even if the defendant can establish a legitimate non-discriminatory reason, the plaintiff may still prevail by demonstrating that the health care provider's legitimate interest can be met by using a less

Motive is practically impossible to prove in an intentional discrimination claim.[189] As with Title VII litigation, minority physicians lack the data likely needed to support a disparate impact claim. Moreover, the defendants' Title VI burden is lower than under Title VII,[190] and for that reason, MCOs can easily provide legitimate non-discriminatory reasons for the challenged criteria.

One of the major difficulties in using Title VI to redress health care discrimination is that Title VI, unlike other Titles of the 1964 Civil Rights Act, depends primarily on administrative rather than judicial enforcement. The Department of Health and Human Services, Office of Civil Rights (DHHS/OCR) has the primary responsibility for ensuring that federally funded health care providers comply with Title VI.[191] Individuals have a private right of action to pursue claims of intentional discrimination, but only DHHS/OCR can enforce claims of disparate impact discrimination.[192] Chronically under-funded and under-staffed, DHHS/OCR's Title VI enforcement record is poor.[193]

The Humana federal court litigation, which is discussed above, illustrates the practical difficulties physicians of color face in using Title VI to obtain relief from managed care's exclusionary practices. Having no private right of action, plaintiffs would have been forced to rely on OCR complaint investigations that are replete with problems, including delays and understaffing. A seven-year delay is not unusual.[194] Further, the lack of data on terminations by race presented an insurmountable obstacle. Plaintiffs rightly sought

discriminatory alternative).

189. *See* Watson, *supra* note 183, at 948-49.

190. *Id.*

191. *Id.*

192. Alexander v. Sandoval, 532 U.S. 275 (2001). *Sandoval* involved a Title VI claim against the Alabama Department of Public Safety. Plaintiffs sought to enjoin the department's practice of administering driver's license tests in English alleging that the practice violated Title VI because of its disparate impact on those with limited English proficiency. A fractured court held that private individuals do not have a private right of action to sue to enforce the Title VI disparate impact regulations. However, many commentators believe that *Sandoval* does not foreclose a section 1983 action to enforce Title VI disparate impact regulations against a governmental actor. *See Leading Cases*, 115 HARV. L. REV. 487 (2001).

193. In 1999, the United States Commission on Civil Rights criticized Title VI enforcement efforts in the area of health care: the Commission's report pointed out that the nondiscrimination provisions have not been fully enforced and implemented by DHHS/OCR. U.S. COMM'N ON CIVIL RIGHTS, THE HEALTH CARE CHALLENGE: ACKNOWLEDGING DISPARITY, CONFRONTING DISCRIMINATION, AND ENSURING EQUALITY: A REPORT OF THE UNITED STATES COMMISSION ON CIVIL RIGHTS 6 (1999).

194. *See* Marianne Engleman Lado, *Unfinished Agenda: The Need for Civil Rights Litigation to Address Race Discrimination and Inequalities in Health Care Delivery*, 6 TEX. F. ON C.L. & C.R. 32-33 (2001).

relief under Florida state law remedies, which may not be available to plaintiffs in other states.

C. Federal Policy Levers: Medicare and Medicaid

Collecting racial data is necessary if racial discrimination in managed care is to be identified and proven. The federal government does not routinely collect provider or patient racial data in health care.[195] To date, nearly all private and foundation-supported data collection efforts have focused on patient race and ethnicity.[196] It is not sufficient to have data about health plan members alone. Provider race is a risk factor that ties into the delivery of appropriate medical care.

Recognizing this, on March 5, 2003, Aetna announced plans to collect data on the race and ethnicity of Aetna's network of participating physicians in a number of ways, including voluntary provider surveys.[197] Aetna stated that the collection of this information will allow the company to address the cultural competency of its provider network and assess their ability to meet the racial, ethnic, cultural and linguistic preferences of its member population.[198] Only a handful of MCOs have followed Aetna's lead.[199]

The Centers for Medicare and Medicaid Services (CMS) have mandated Quality Assessment and Performance Improvement (QAPI) initiatives as a condition of participation in Medicare Advantage plans,[200] and Medicaid managed care plans.[201] "Quality assessment" requires health plans to measure scientifically validated indicators of care such as vaccination rates and health screening rates.[202] "Performance improvement" requires plans to use targeted

195. *See* NATIONAL RESEARCH COUNCIL, ELIMINATING HEALTH DISPARITIES: MEASUREMENT AND DATA NEEDS (Michele Ver Ploeg & Edward Perrin eds., 2004).

196. *See* AMERICA'S HEALTH INSURANCE PLANS, COLLECTION OF RACIAL AND ETHNIC DATA BY HEALTH PLANS TO ADDRESS DISPARITIES: FINAL SUMMARY REPORT. (2005) [hereinafter "AMERICA'S HEALTH INSURANCE PLANS"].

197. AETNA, AETNA ANNOUNCES INITIATIVES TO REDUCE THE RISK ASSOCIATED WITH RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE (2003), *available at* http://www.aetna.com/news/2003/pr_20030305.htm.

198. *Id.*

199. *See* AMERICA'S HEALTH INSURANCE PLANS, *supra* note 196, at 13.

200. *See* 42 U.S.C § 1395w-22(e); 42 C.F.R § 422.152 (2005). The Medicare Modernization Act changed the name of private Medicare managed care plans from Medicare+Choice to Medicare Advantage.

201. *See* 42 U.S.C. § 1396u-2(c); 42 C.F.R. § 438.240 (2003).

202. *See* 42 C.F.R § 422.152; *see also* Sidney D. Watson, *Equity Measures and Systems Reform as Tools For Reducing Racial and Ethnic Disparities in Health Care* (Commonwealth

interventions in specific areas, set goals, and collect data to measure performance improvements.[203]

In 2000, Congress amended the Social Security Act to require that QAPI programs include a separate focus on racial and ethnic minorities.[204] In 2003, CMS gave private Medicare managed care plans a choice; either focus on (1) culturally and linguistically appropriate services (CLAS initiatives), or (2) health disparities affecting Native Americans, Asian Americans, African Americans and Latinos/as (Equity initiatives).[205] CMS has provided plenty of technical support for plans choosing to implement the CLAS initiatives, but done little, if anything, to support plans choosing to implement Equity initiatives.[206] It is unclear how many plans have chosen to measure racial and ethnic minority health disparities.[207] Just as guidance is needed for CLAS initiatives, guidance is also needed for Equity initiatives.

Although CMS appears to have the regulatory authority to require Medicare MCOs to collect physician race and ethnicity data to support Equity initiatives, current QAPI requirements do not mandate that health plans engage in Equity initiatives, or track performance data by race and ethnicity.[208] Equity measures that fail to track race and ethnicity likely miss obvious inequities in the medical treatment provided to patients of color. Equally important, race-blind Equity initiatives likely ignore the quality-enhancing role of race-concordant patient/physician relationships.

Equity and fairness are generally considered fundamental concepts that guide the distribution of social insurance benefits.[209]

Fund, Publication No. 776, 2005).

203. *See* 42 C.F.R. § 438.240; Watson, *supra* note 202, at 2-4.

204. *See* HR 5661 § 616(b)(5)(b), 106th Cong., 2, (2000), codified at 42 U.S.C. 1395w-222(e).

205. Centers for Medicare and Medicaid Services, *Medicare Managed Care Manual*, Chapter 5, section 20.3.3.1, March 18, 2005.

206. *See* Watson, *supra* note 202, at 7; Agency for Healthcare Research and Quality, *Oral, Linguistic, and Culturally Competent Services: Guides for Managed Care Plans*, Feb. 2003, *available at* http://www.ahrq.gov/about/cods/cultcomp.htm.

207. *See* Watson, *supra* note 202, at 7.

208. *See* Watson, *supra* note 202, at 9-10. Professor Sidney Watson has shown that CMS' interpretation of the Medicare Prescription Drug, Improvement and Modernization Act allows the agency sufficient authority to require Medicare Advantage plans to submit quality and performance measures stratified by race and ethnicity. Collecting provider race and ethnicity data is arguably consistent with the agency's health care disparities regulations because such provider composition data is among the indices of the quality of care ethnic and racial minorities receive under private Medicare managed care health plans. *Medicare Managed Care Manual*, Chapter 5 § 20.3.3.1.

209. *See* STRENGTHENING COMMUNITY: SOCIAL INSURANCE IN A DIVERSE AMERICA 3 (Kathleen Buto et al. eds., 2004).

Managed care, however, is not structured in a manner that assigns equal weight to the preferences and outcomes of minority patients. Revising QAPI requirements is one way that Congress can level the playing field by requiring MCOs to assess equity and fairness through the lens of race and ethnicity. This would bring into sharp focus the bond between minority providers and minority patients.

Considerations of this sort suggest that Congress should strongly consider amending the various sections of the Social Security Act that mandate QAPI programs for private MCOs providing Medicare and Medicaid health plans. Specifically, congress should: (1) require that private managed care Medicare and Medicaid plans engage in Equity initiatives as well as CLAS initiatives, (2) require that equity data be stratified by race, ethnicity and gender, and (3) mandate that managed care Medicare and Medicaid plans provide data on the racial and ethnic composition of provider networks. Congress is currently considering a number of revisions to the NMA. This provides a perfect opportunity to consider issues of equity and fairness in the provision of Medicare and Medicaid services by MCOs.

V. State and Local Legislation and Reforms

The foregoing discussion suggests that existing federal civil rights laws are not up to the challenge of correcting market-based health care discrimination. Congress can modify existing Social Security regulations, but this requires a great deal of political will and a commitment to racial equity in health care. Simply put, our society has failed to identify and describe the health needs of minority Americans as a problem of sufficient urgency and magnitude so as to attract broad coalitions capable of commanding attention and initiating a political discourse about federal solutions.

Local and state governments, however, have acted to correct some of the race and class-based injustices in managed care's provider selection and de-selection process. These remedies focus on equity and due process.

A. Provider Diversity Ordinances

On March 21, 1996, the Baltimore City Council passed the nation's only city ordinance that requires MCOs contracting with

the city to have minority doctors and dentists as plan providers.[210] The Ethnically Diverse Health Care Panels ordinance does not use quotas or give preferential treatment to minority providers. Instead, the ordinance provides that the ethnic diversity of the provider panel is among the criteria the city will use to award health services contracts for city employees.[211] The story of the origins of the Baltimore ordinance illustrates the complex interplay between race and profit-driven business decisions, and the struggle of black physicians to protect their patients and themselves.

Managed care health plans were attracted to Maryland because of its affluence and the presence of nationally renowned medical centers such as Johns Hopkins.[212] The Baltimore strategy was simple: Enter the market by first signing up patients in the predominately white suburbs to ensure the largest profits, a business practice know as "cherry picking." As competition increased, health plans began expanding their provider networks by targeting middle-and working-class black patients, the mainstay of black physician practices.[213] City employees, in particular, were aggressively targeted. Black physicians reported hearing stories from their patients of being wined and dined by managed care plans, promised cheaper coverage than their traditional Blue Cross/Blue Shield plan, and promised continued coverage for visits to black physicians they were currently seeing.[214]

The promise of continued coverage for black providers proved untrue. For instance, members of the nearly two-thirds black teacher's union, which had signed on with an HMO, were given a book that contained their list of providers; of the 27 primary care physicians listed, only one was black and all others white.[215] Black physicians and patients alike were outraged. Some patients refused

210. JOURNAL CITY COUNCIL BALTIMORE, March 21, 1996 (codified at BALTIMORE, MD., CODE Art. 1 § 27 (1998)).

211. *Id.* § 27 (C) ("Any person who submits to the city a bid or who contracts with the city to be a heath care carrier or to provide health care services to Baltimore city employees or persons receiving health care through any entity funded by the city shall prequalify . . . criteria for the prequalification of health care carriers shall include, but not be limited to: (1) Experience Levels (2) Financial History and (3) Ethnic diversity of their respective provider panels.").

212. All Things Considered, National Public Radio, *Minority Doctors Say They Can't Get Into HMOs*, Nov. 14, 1996 (copy of transcript on file with author).

213. *See* National Public Radio, *supra* note 212.

214. *Id.* According to Dr. Lenox Dingle: "[MCOs] had a picnic and invited [black patients'] families and had entertainment and some games. And basically what they did is sold these teachers into purchasing a health care plan. It was cheaper than their traditional Blue Cross and Blue Shield card. But they said that, you know, we'll--you'll have me covered as well."

215. *Id.*

to choose a primary care physician.[216] The local NMA chapter received numerous complaints from members alleging that their applications for membership in provider networks had been rejected. The most common explanation for the rejection, when one was given, was that the network had been filled. Other members alleged that they were dropped from the network shortly after being listed as a participating provider.[217]

Black physicians and dentists initially sought relief from the Maryland General Assembly. Black legislators drafted and introduced an HMO diversity bill aimed at prohibiting discrimination by HMOs, preserving the relationship between minority patients and their physicians, protecting the quality and availability of health care to underserved populations, and expanding the business opportunities of minority providers.[218] The bill never reached the floor for a vote.

The physicians and dentists shifted the focus to the local level, asking the Baltimore City Council to pass an ordinance that would require HMOs to accept more black doctors into citywide health plans.[219] At first, the city council passed a January 29, 1996, resolution urging the General Assembly to adopt the HMO Diversity Bill.[220] The resolution expressed the city council's view on

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216. *Id.*

217. Black Baltimore area physicians frequently turned to the press to air their grievances. *The Baltimore Sun* published a number of articles describing their complaints. Some of the personal narratives include Dr. Willlarda V. Edwards, an internist, who tells of applying to more than half a dozen HMOs operating in the Baltimore region and being turned down by each one. At the time, she had a large practice in a working and middle class suburb, had never been sued, and was the president of a medical association that represented almost 300 black doctors in the Baltimore region. Dr. Edwards thought the she was turned down because her patients tend to be sicker: "It's about making a profit. And so they want well patients. Then they want doctors who have the low-cost patients. I see it as discrimination." *See* Diana K. Sugg, *Black Doctors Feel Chill at HMOs*, THE BALTIMORE SUN, Nov. 8, 1995, at A1.

Complaints about de-selection include those of Dr. Francine Higgs-Shipman, a board-certified internist, who describes how she first lost 300 patients when Prudential HMO dropped her, and then lost an additional 100 patients when Cigna dropped her. According to Dr. Higgs-Shipman, Cigna informed her that she was spending too much money per patient. *Id.* Black dentists, such as Billy D. Davis also complained of being dropped. Dr. Davis claimed that he and several of his colleagues were the targets of intense HMO scrutiny and were removed from HMO provider lists or denied access. *See* Robert Guy Matthews, *Bill to Force HMOs to Take More Black Doctors Stalls; Hearing Panel Cites Weaknesses in Proposal to Quell Alleged Racism*, THE BALTIMORE SUN, Nov. 9, 1995, at B5.

218. H.B. 116, 1995 Leg., 7th Sess. (Md. 1995).

219. *See* Robert Guy Matthews, *Council Gives Okay to HMO Diversity Bill*, THE BALTIMORE SUN, Mar. 26, 1996, at B3.

220. Baltimore City Council, Resolution 30, Jan. 29, 1996, reprinted in Journal City Council of Baltimore, Jan. 29, 1996 (copy on file with author).

managed care and people of color:

> While the nation's health care industry moves towards managed care, a disproportionate percentage of minority health care providers have been systematically denied access to or excluded from the managed care system [and] . . . the exclusion from the managed care system of minority health providers, who are experienced in the special health needs of minority patients will deleteriously affect the quality of treatment and care delivered to minority patients.[221]

Copies of the resolution were sent to the Governor of Maryland, the President of the Senate and the Speaker of the House.[222] Lacking a response from the General Assembly, the Baltimore City Council drafted and adopted the March 1996 Ethnically Diverse Health Care Panels.

The Baltimore ordinance provides an incentive for MCOs to diversify, or, at a minimum, requires MCOs to think about issues of race and ethnicity. Because provider network racial and ethnic diversity is only one factor among several the city considers before awarding health care contracts, the ordinance is consistent with recent court decisions discussing issues of race and diversity.[223] Physicians of color excluded from provider networks in other large cities, especially those with substantial minority populations, should carefully consider the Baltimore example and seek relief at the local level.

B. State Legislative Responses

Nearly every state has some law or administrative regulation that provides consumer protection or provider protection against MCO practices. Most of these statutes were passed during the 1990s as part of a widespread and deep-seated "backlash" against the perceived overreaching of managed care and market forces in health care. Scholars from both ends of the political spectrum have soundly criticized these laws. From the left, Deborah Stone argues that they cater to the interests of people with insurance and divert

221. *Id.*

222. *Id.*

223. *See* Grutter v. Bollinger, 539 U.S. 306 (2003) (stating that the use of race as one factor in law school admissions is allowable to achieve diversity); *see also* City of Richmond v. J.A. Croson, 488 U.S. 469 (plurality opinion) (stating that racial preferences in city contracting may be used only to remedy government's participation in industry-wide race discrimination).

attention from the plight of those with no insurance.[224] From the right, Clark Havighurst argues that the standards set by these laws are designed to suit the preferences of an aware, affluent, and politically active minority, and the interests of health care providers, at the expense of ordinary consumers who are denied the freedom to spend their limited incomes in ways that maximize their welfare.[225]

These observations are likely true as they pertain to much consumer protection legislation, but they ignore the equalizing role of certain provider protection laws such as patient advocacy laws and anti-gag rule legislation, that vindicate the rights of physicians while allowing them to fulfill their fiduciary obligation to act on the patients' behalf. Laws of this sort "equalize" by altering the balance of power between providers, consumers, and MCOs.[226]

At least twelve states have enacted health care provider "due process" laws.[227] These laws attempt to equalize by providing some measure of due process protection to "difficult" or "unpopular" providers and allow consumers continuity of care. The statutes differ in the amount of protection provided. For instance, the Delaware statute offers little protection, requiring health plans to provide written notice of the reasons for termination or non-renewal of a provider contract only if the physician requests such notice within twenty days,[228] and requiring only "administrative review" of the termination, without specifying the parameters of the review.[229]

On the other hand, the New York due process statute is much more protective. First of all, it clearly enumerates the procedures that constitute adequate due process. The statute requires: (1) a written explanation of the reasons for the proposed termination;[230] (2) notice that providers are entitled to request a hearing or review by a panel appointed by the health care plan;[231] (3) a hearing before that panel, a third of whose members must be clinicians in the same

224. *See* Deborah Stone, *Managed Care and the Second Great Transformation*, 24 J. HEALTH POL. POL'Y & L. 1213 (1999).

225. *See* Clark Havighurst, *The Backlash Against Managed Health Care: Hard Politics Make Bad Policy*, 34 IND. L. REV. 398 (2001)

226. *See* Linda C. Fentiman, *Patient Advocacy and Termination from Managed Care Organizations: Do State Laws Protecting Health Care Professional Advocacy Make Any Difference?*, 82 NEB. L. REV. 508, 511-12 (2003).

227. *See* BARRY R. FURROW ET AL., HEALTH LAW 494 (2000).

228. DEL. CODE ANN. tit. 18, § 3339(c) (2003).

229. *Id.*

230. N.Y. PUB HEALTH LAW § 4406-d(2)(a)-(b)(i) (2005).

231. *Id.* § 4406-d(2)(b)(2). The statute also requires reasonable time limits for actions that are short enough to ensure that the process does not drag out interminably but long enough to permit a provider to prepare and present a case.

specialty as the physician under review;[232] and (4) written notice of the panel's decision.[233]The statute also lists impermissible reasons for contract termination. Specifically, the statute states that a physician cannot be terminated from a preferred provider list for: (1) advocating on behalf of an enrollee; (2) filing a complaint against the health care plan; (3) appealing a decision of the health care plan; (4) providing information or filing a report; or (5) requesting a hearing or review.[234]

Of particular importance, the statute requires case mix adjustment. Health care plans are required to look beyond economic profiling numbers and measure individual physician economic profiles against other physicians serving comparable patient populations.[235] Further, a physician threatened with de-selection must also have the opportunity to review the data and "discuss the unique nature of the [physician's] patient population which may have a bearing on the [physician's] profile and to work cooperatively with the health plan to improve performance."[236]

More specifically, New York requires MCOs to (1) develop methodologies to collect and analyze health care provider profiling data in consultation with providers, (2) use the data to evaluate providers against objective agreed upon criteria and to compare providers who treat comparable patient population, (3) have policies and procedures to ensure that providers are informed of the information which is used to evaluate their performance, (4) disclose these data periodically to providers, and (5) provide providers with an opportunity to respond to the MCOs assessment of their performance, including clarification of the nature of their patient population, and working cooperatively with the MCO to improve their performance.[237]

In race-neutral terms, the statute effectively addresses many of the concerns raised by physicians of color who have been dropped from provider networks. The case mix adjustment provision potentially provides an accurate assessment of physician cost-effectiveness by requiring managed care health plans to take into account the fact that physicians of color disproportionately care for sicker, poorer and more costly patients. A well-crafted law of this type can provide essential ammunition for physicians of color to

232. *Id.* § 4406-d(2)(c).

233. *Id.* § 4406-d and e. Exceptions to the statute are provided for cases involving imminent harm to patient care, fraud, or a final disciplinary action by a government agency that "impairs the [physician's] ability to practice [medicine]." *Id.* § 4406-d(2)(a).

234. *Id.* § 4406-d(5).

235. *Id.* § 4406-d(4).

236. *Id.*

237. *Id.*

defend against claims that they were terminated because of "inefficiency" or "high deficits," because the statute requires that MCOs provide relatively objective criteria, chosen in advance by the MCO, by which the physician's satisfaction of their contract requirements can be measured.

A major shortcoming, however, is that the statute does not explicitly provide for any means of enforcement. The New York Supreme Court, Appellate Division, reached that issue in *Foong v. Empire Blue Cross and Blue Shield,*[238] and found an implied right of action within the statute. In that case, defendant health plan terminated plaintiff's contract on the basis of imminent harm to patients, but waited thirteen months after first notifying him of his alleged substandard care.[239] The New York County Medical Society later found that plaintiff had demonstrated sound medical practice. Plaintiff sued the Empire Blue Cross and Blue Shield for breach of contract and breach of the common law duty of good faith and fair dealing.[240] The court held that plaintiff has an implied private right of action under the statute, allowing the claims to proceed in state court.[241] Further, the court made clear that termination actions by health plans, including associated peer review decisions, are subject to judicial review.[242]

Another key question is whether ERISA[243] preempts provider due process statutes. In *Kentucky Association of Health Plans v. Miller,*[244] the Supreme Court abandoned its precedents and crafted a new and clearer approach to the ERISA preemption problem. At issue was Kentucky's "any willing provider" statute.[245]

The Court's prior ERISA "savings clause" analysis had created substantial confusion. Basically, a state regulation that has some effect on an MCO is preempted, unless the law is one that the state has enacted to regulate the business of insurance.[246] In *Kentucky*

238. 762 N.Y.S.2d 348 (N.Y. App. Div. 2003).
239. *Id.*
240. *Id.*
241. *Id.*
242. *Id.*
243. Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1003 (2000)
244. 538 U.S. 329 (2003).
245. *Id.*
246. The savings clause is found in 29 U.S.C.A. § 114(b)(2)(A). In its early cases interpreting this clause, the Court read it conservatively, applying both a "common sense" as well as a three part test developed in antitrust cases applying the McCarran-Ferguson Act for determining whether a law regulated the business of insurance. *See* Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985). In the late 1990s, however, the Court began to back off of its earlier mechanical and restrictive approach. *See* UNUM Life Ins. Co. v. Ward, 526 U.S. 358 (1999) (stating that the McCarran-Ferguson factors were merely relevant factors to a determination of whether the savings

Association, Plaintiff health plans had argued that the law was not saved from ERISA preemption because it was not directed at the insurance industry and applied equally to health care providers. In rejecting this position, the Court announced a new two-part saving clause analysis:

> Today we make a clean break from the McCarran-Ferguson factors and hold that for a state law to be deemed a law . . . which regulates insurance under § 1144 (b)(2)(A), it must satisfy two requirements. First the state law must be specifically directed toward entities engaged in insurance. Second . . . the state law must substantially affect the risk pooling arrangement between the insurer and the insured.[247]

Earlier in the opinion the court had interpreted the "risk pooling" requirement as follows: "We have never held that state laws must alter or control the actual terms of insurance policies to be deemed laws . . . which regulate insurance under § 1144(b)(2)(A); it suffices that they substantially affect the risk pooling arrangement between insurer and insured."[248]

The Court reasoned that the laws were specifically directed toward entities engaged in insurance because the law imposed no legal obligations on physician providers.[249] The Court also reasoned that by restricting health plans' ability to limit the number of providers with access to their network, the law also restricted the ability of health plans to offer lower payments to providers in exchange for the assurance of high patient volume.[250] This, in turn, "substantially affected the risk pooling arrangement between the

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clause should apply and not conclusive).

Section 2 of the McCarran-Ferguson Act provides:

> (a) *The business of insurance,* and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
>
> (b) No Act of Congress shall be construed to invalidate, impair, or supersede *any law enacted by any State for the purpose of regulating the business of insurance,* or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided,* That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

59 Stat. 34, 15 U.S.C. § 1012 (emphasis added).

247. Ky. Ass'n of Health Plans v. Miller, 538 U.S. 329, 341-42 (2003).

248. *Id.* at 338.

249. *Id.* at 335.

250. *Id.* at 335-36.

insurer and the insured" because the law prohibited Kentucky's insureds from seeking insurance through a closed network of health care providers in exchange for lower premiums.[251]

Kentucky Association significantly clarifies and expands the coverage of ERISA's saving clause, allowing more state laws regulating MCOs to escape preemption. Applying the Court's analysis to provider due process laws, these laws are specifically directed toward entities engaged in insurance because like Kentucky's "any willing provider" law, the due process legislation does not impose any obligation on providers. The second *Kentucky Association* prong is also likely met. First, by restricting the ability of MCOs to terminate providers without costly due process procedures, it thereby limits heath plan's ability to offer discounted rates to providers in exchange for lower due process protection. This, in turn, "substantially affects the type of risk pooling arrangements that insurers may offer insured" because the law restricts New York's insured from seeking insurance from a network of providers lacking due process protections in exchange for lower premiums.

In sum, provider due process statutes, like New York's, provide physicians of color much needed protection against unfair terminations, and appear to escape ERISA preemption. Having less leverage and negotiating power than other provider groups, physicians of color benefit most from due process statutes. As law Professor Rebecca Zietlow observes, individuals who have faced historical discrimination, including women, people of color and the poor, have more to gain from formal procedures.[252] Decision-makers are less likely to act on prejudice if they are constrained by formal procedures.[253] Procedural protections also limit power imbalances by allowing individuals to participate in decisions that affect their lives.[254]

One limitation is that the due process statutes address terminations only, while many physicians of color allege that they are rejected in the first instance. A more protective statute should include some explanation for the rejection as well as proof that the

251. *Id.* at 342.

252. *See* Rebecca Zietlow, *Giving Substance to the Due Process Counterrevolution*, 75 DEN. U. L. REV. 9, 32 (1997).

253. *Id. See also* Richard Delgado et al., *Fairness and Formality: Minimizing the Risk of Prejudice in Alternative Dispute Resolution*, 1985 WIS. L. REV. 1359, 1387-89 (stating that without procedural formalities, decision-makers are more likely to be swayed by prejudice); Owen M. Fiss, *Against Settlement*, 93 YALE L.J. 1073, 1076 (1984) (stating that poorer parties are disadvantaged in the bargaining process because of their limited resources to finance litigation).

254. *See* Fiss, *supra* note 253, at 1077-78.

reasons given are not pretexual. Further, the enforcement mechanism should be stated clearly.

C. Judicial responses

Physicians have traditionally been considered independent contractors when providing services to MCOs and hospitals.[255] Under such circumstances, MCOs have inserted "termination without cause" provisions, and the courts have routinely upheld them under theories of breach of contract, antitrust analysis, and constitutional law.[256]

Since the mid-1990s, however, courts have issued a number of significant opinions concerning the ability of MCOs to de-select physicians from their managed care networks by exercising their rights under without cause termination provisions in provider agreements. These cases apply contract principles in finding that a termination is either void as against public policy, or violates the common law of fair procedure.[257]

In *Harper v. Healthsource New Hampshire, Inc.*,[258] Dr. Harper, a primary and surgical care provider, had participated in the physician network established by Healthsource New Hampshire since its inception in 1985, and approximately thirty-forty percent of

255. Raglin v. HMO Ill., Inc., 585 N.E.2d 153, 156 (Ill. App. Ct. 1992) ("In this case there seems to be no question that HMOI is an IPA model health maintenance organization and, therefore, does not directly employ its own physicians.... For this reason the medical groups, and thus the physicians who work within the medical group, may be considered independent contractors...."); Biddle v. Sartori Mem'l Hosp., 518 N.W.2d 795, 797 (Iowa 1994) ("a physician is customarily regarded as an independent contractor, not an employee of the facility served.")

256. Bryan A. Liang, *Deselection under* Harper v. Healthsource*: A Blow for Maintaining Patient-Physician Relationships in the Era of Managed Care*, 72 NOTRE DAME L. REV. 799, 845-49 (collecting and summarizing cases).

257. The California Supreme Court recently relied on the common law of fair procedure in Potvin v. Metro. Life Ins. Co., 22 Cal. 4th 1060 (2000). Regarding de-selection from a preferred provider list, the court stated that the right of fair procedure "does not apply to an insurer's removal of a physician from its preferred provider list *unless* the insurer possesses power so substantial that the removal significantly impairs the ability of an ordinary, competent physician to practice medicine or a medical specialty in a particular geographic area, thereby affecting an important, substantial economic interest." *Id.* at 1072-73. Even when the right applies, the court stated that an insurer is free to de-select a physician from its preferred provider list, so long as the decision is "substantively rational and procedurally fair." *Id.* This decision is helpful to minority physicians in states like California and Pennsylvania that have a common law right of fair procedure.

258. 674 A.2d 962 (N.H. 1996)

Dr. Harper's patient base was Healthsource-related.[259] Healthsource's participation agreement with Dr. Harper permitted the HMO to terminate the relationship both with and without cause.[260]

In 1994, Dr. Harper concluded that Healthsource had been manipulating his patients' treatment records. After notifying Healthsource of his concern, Healthsource informed Dr. Harper that it was terminating his participation agreement for cause because he had not satisfied the HMOs re-credentialing criteria. Dr. Harper appealed this decision within Healthsource, and, ultimately, Healthsource's Executive Management Committee overturned the decision to terminate Dr. Harper for cause but decided to terminate him without cause.[261] Dr. Harper sued Healthsource, alleging numerous causes of action, including violations of public policy and due process. The trial court granted Healthsource's motion to dismiss.[262]

The New Hampshire Supreme Court reversed, finding the termination without cause provision is limited by the implied covenant of good faith and by public policy. It concluded that a physician is entitled to review of a de-selection decision to determine whether the decision "comport[ed] with the covenant of good faith and fair dealing and [whether it was] made for a reason that is contrary to public policy."[263] According to the court, the public has a substantial interest in the relationship between HMOs and provider doctors.[264] In light of Dr. Harper's allegation that his termination without cause constituted retaliation for his attempts to correct patient records, the court determined that his claim that Healthsource's termination decision had been made in bad faith or in a manner contrary to public policy should be heard.[265]

The *Harper* court, however, did not reject termination without cause provisions in all physician/HMO disputes. The physician must show that the HMO terminated the relationship without cause and the physician must believe that the decision to terminate was made in bad faith or on a basis contrary to public policy.[266] The

259. *Id.* at 963.
260. *Id.* at 964.
261. *Id.* at 963-64.
262. *Id.* at 964.
263. *Id.* at 965.
264. *Id.* at 966 (finding that the doctor-patient relationship is one of many which are afforded a special place by society, and that similar values are reflected in New Hampshire statutes which require preferred provider agreements to be fair and in the public interest).
265. *Id.* at 966-67.
266. *Id.*

Harper "public policy" defense is especially important to physicians of color who frequently allege that they were terminated from health plans because their patients are sicker and cost the plan too much money. As Liang has suggested, this defense should be used to preserve the patient-physician relationship if the physician has patients who are vulnerable and wish to continue the relationship.[267] For those minority physicians not protected by due process statutes or diversity ordinances, the *Harper* "public policy" defense is an avenue worth pursuing.

Conclusion

Managed care joins together three actors—insurers, physicians and health care institutions—each having a history of discrimination against physicians of color and the patients they serve. Factor in the profit motive, and the situation is ripe for unfair treatment. While MCOs do not appear to purposefully discriminate, the use of historical and race-blind selection and de-selection criteria inaccurately measure the efficiency and the quality of care provided by minority physicians.

While a strong argument can be made for race-conscious remedies, there are a host of practical and legal issues associated with mandates requiring either race-pairing or specific numbers of minority physician providers. For this reason, remedies that do not specifically exclude white physicians are advisable. Well-drafted physician due process statutes and diversity ordinances implicitly consider physician and patient race and ethnicity without penalizing majority group providers. Further, Equity initiatives that require the collection of both provider and patient racial and ethnic data further the goal of ensuring that MCOs take into account the special bond between minority providers and minority patients.

267. Liang, *supra* note 256, at 858.